with hypertrichosis. General disorders causing hypertrichosis include porphyria, Hurler's syndrome, dermatomyositis, teratoma, thymic tumours, mumps, malnutrition, acromegaly, hypertrichosis lanuginosa and racial and hereditary variations[10].

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Subcutaneous *Salmonella* abscess - an unusual manifestation of salmonellosis

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Suppurative abscesses due to focal infection with *Salmonella* is uncommon with an overall incidence of up to 1.7%[1]. We report a case of an elderly man with a subcutaneous abscess of the chest wall.

Case report

Mr AD, aged 86 years, initially presented with a one-month history of cough productive of white sputum, breathlessness and weight loss, with no previous history of respiratory or cardiac disease. Examination revealed a left sided pleural effusion extending to the sixth posterior rib interspace with no radiological evidence of heart failure. Routine investigations were normal including the white cell count. Pleural aspiration to dryness yielded a straw coloured exudate (protein content 36 g/l) with no malignant cells. Microscopy and culture revealed no organisms. The patient improved symptomatically was discharged with a diagnosis of likely underlying malignancy of the lung. A small left sided pleural effusion persisted.

He re-presented 6 months later increasingly breathless due to reaccumulation of the pleural effusion. He was noted to be unwell but apyrexial with a small hard swelling in the left posterior axillary line, overlying the previous pleural aspiration, presumed to be a metastatic seedling. It grew in size and eventually burst 2 weeks later, draining a thick, purulent, blood-stained fluid. High dose ampicillin, gentamicin and metronidazole were commenced while awaiting bacteriological diagnosis. *Salmonella typhimurium* Phage type 12 was isolated from the abscess fluid. Sputum culture was negative. Faeces and urine, cultured after antibiotic therapy, were persistently negative for the next 2 months. The abscess and pleural effusion responded promptly to antibiotics and completely subsided within a month with no evidence of recurrence of either.

Discussion

Focal infection is one of the four classical clinical patterns of salmonellosis[2,3], being the predominant finding in only 8% of all patients[2]. The majority (26%) were intra-abdominal infections such as appendicitis and cholecystitis. Twenty-four per cent were due to soft tissue abscesses with an incidence of 0.0-1.7%[2]. No abscesses were found in patients with non-typhoidal *Salmonella*[4]. Abscesses are frequently related to the gastrointestinal tract and a few cases of subcutaneous abscesses have been reported[5]. It is highly likely that the location of the abscess in our patient to the posterior chest wall was related to the previous pleural aspiration and biopsy. Such localization to sites of trauma has been reported[6].

The source of the infecting organism was not detected. No previous history suggestive of *Salmonella* infection was obtained, which is often the case[2]. Blood cultures prior to therapy were negative. Stools and urine were unfortunately not examined prior to antibiotic therapy, thus the existence of a carrier state could not be ruled out. Permanent carrier states of *Salmonella*, with the exception of *S. typhi* are, however, rare[3]. There was no evidence pointing to osteomyelitis of the ribs or lung infection.

Increased host susceptibility to infection secondary to lowered resistance due to debilitating disease is an important determinant of *Salmonella* infection[1-3,6]. None of these contributory factors could be identified in our patient. He was elderly and, although generally debilitated, made a remarkable recovery. No evidence of malignancy has as yet emerged.

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